OFFICE OF THE INSPECTOR GENERAL

DMHMRSAS

SNAPSHOT INSPECTION

CENTRAL STATE HOSPITAL

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INSPECTOR GENERAL

OIG REPORT # 66-02

EXECUTIVE SUMMARY

A Snapshot Inspection was conducted at Central State Hospital in Petersburg, Virginia during July 30, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

During this inspection, the facility was noted to be clean, comfortable and well maintained. Members of the inspection team had difficulty determining the procedure for accessing Buildings 93 and 94 during the second shift as neither building provides for instructions regarding entry. After several attempts to enter Building 93, a team member followed a group of patients into the building that were returning from an outing without anyone questioning the purpose for the visit or the team member's identity.

Staffing patterns were consistent with facility expectations for coverage during the second shift. Staff interviews indicated that overtime had been steadily increasing during the past several months. This was attributed to vacation requests, staff shortages and call-ins. Interviews revealed that the facility offers support for staff members seeking career advancement of which several expressed interest in participating in the courses that are to be conjointly offered on campus through a cooperative effort between SVTC and the local community college.

Record reviews revealed maturity in the psychosocial rehabilitation programs and the documentation of active treatment goals. The goals were clearly linked to assessments and focused on individualized barriers to discharge.

The Local Human Rights Committee had not been able to maintain a quorum in order to approve policy and procedure changes which resulted from the human rights regulations promulgated in November 2001. This delay prohibits this body from successfully executing it responsibilities and needs to be addressed by the Office of Human Rights.

Facility: Central State Hospital

Date: July 30, 2002

Type of Inspection: Unannounced Snapshot Inspection

Reviewers: Cathy Hill, MEd

Heather Glissman, BA

Purpose of the Inspection: To conduct a snapshot inspection of the general environmental conditions, staffing patterns and activities of the patients.

Sources of Information: Interviews were conducted with both administrative and clinical staff. Patients were also interviewed. Documentation reviews, included but was not limited to; patient(s) medical records, staff schedule sheets, program descriptions and activity/program schedules. Activities and staff/patient interactions were observed during a tour of the facility.

GENERAL ENVIRONMENTAL ISSUES

Finding 1.1: Overall, the buildings toured were clean, comfortable and well maintained.

Background: Tours were completed during the day shift in Building 114 (civil active treatment mall) and Building 96. Buildings 93 and 94 were toured during the evening shift. All were noted to be clean and comfortable. The units were well maintained with adequate lighting. The living quarters, including bathrooms were clean and free of odors. The furniture was in good repair and comfortable. Temperatures on the units were noted by the team and identified by residents as comfortable despite record high summer temperatures.

During the day all civil patients go to Building 114 for active treatment. In spite of the heavy traffic this creates, the staff and patients have successfully been able to maintain an environment that is free of clutter and mess. The two cafeterias in Building 114 are cleaned after each lunch shift providing a neat and pleasant atmosphere for the incoming lunch shift.

Building 96 is one of the forensic units and houses its own active treatment mall. The tour of the mall and living quarters revealed a comfortable, nicely decorated, pleasant environment designed to meet both active treatment and residential needs.

Building 93 and 94 housed civil co-ed residential units. Each unit has a large dayroom area designed to accommodate patients engaged in a variety of social activities. There is a television and radio available, game tables and groupings of chairs. The common areas are decorated with stenciling, valences and some pictures. The bedrooms, which extend off the dayroom, were neat and organized.

Recommendation: Preserve the current focus on maintaining a clean, odor free and comfortable environment that enhances treatment.

DMHMRSAS Response: DMHMRSAS concurs, and is gratified at the OIG's recognition of the positive advances made in the ward environments at CSH. Monitoring of all patient care area environments, both from a housekeeping and an aesthetic standpoint, will be ongoing.

Finding 1.2: Buildings 93 and 94 did not provide adequate instruction for visitors regarding entry into the buildings.

Background: The OIG team conducted evening inspections in Buildings 93 and 94. Neither building provides instructions for securing entry into the building for visitors. For example, outside the door to the entry to Building 94 there were two telephones mounted and a red button but nothing to indicate how to alert staff of one's presence. The team member attempting to enter Building 94 went to a different entrance and flagged down staff in an effort to enter the building. The member was instructed through the glass to go back to the main door but no one came to check on the purpose of the team member's desire to enter the building. When the team member went back to the alternate door, a staff member indicated that entry could only occur at the main door, however again no

one came to check on the team member or question the reason for being on campus. *At no time were instructions offered to the team member on the proper procedures for access into the building* Instead the team member just followed a group of patients into the building that were returning from an outing. *Staff members did not ask for identification but allowed the team member to enter the building unquestioned.*

Having a family member or significant other in the hospital is often very difficult. Being ignored by staff or not being provided with proper instructions is an unacceptable practice. In addition, the breach in security was of concern to the team.

Recommendation: Post instructions outside of the door regarding procedures for entry into the building. Train staff regarding security expectations.

DMHMRSAS Response: DMHMRSAS concurs. A CSH Task Force currently is re-evaluating all aspects of visitation, to include: policy formulation, family notification regarding visitation times and contraband issues, space accommodations, access to the buildings and signage. The issues of access and signage will be given priority and work on these will begin immediately. The CSH Director of Nursing will initiate a needs assessment no later than October 4, 2002. Upon completion of the assessment, an operational plan will be developed to ensure appropriate access. Signage and any necessary plant modification (i.e., wiring) will be identified and ordered no later than November 15, 2002.

A memorandum will be sent to all facility staff to remind them of the security issues related to failure of diligence in checking identification of persons entering the buildings.

STAFFING ISSUES

Finding 2.1: Staffing patterns were adequate and consistent with the facility's expectations.

Background: Staffing patterns were as following in the units toured during the second shift on the day of the inspection:

Building 94 –	1 RN / 3 DSA	17 patients
	1 RN/3 DSA	18 patients
Building 93 -	1RN/1 LPN/ 3 DSAs	24 patients
	1 RN / 4 DSAs	23 patients

In Building 93, the RN and 2 of the 4 DSAs were completing at least six hours each of mandatory overtime.

Recommendation: Maintain staffing patterns that meet facility expectations while monitoring the use of mandatory overtime to prevent staff "burn-out" and decreased morale.

DMHMRSAS Response: DMHMRSAS concurs. CSH will maintain adequate staffing levels according to hospital guidelines. Overtime will continue to be monitored, analyzed and decreased whenever possible. The amount of overtime used is driven by a number of factors, such as the number of vacancies, the number of staff out on vacation or sick leave, the number of patients scheduled for medical appointments outside of CSH, and the number of patients requiring one-to-one coverage for safety or medical reasons. More in-depth analysis is being done to differentiate between mandatory and voluntary overtime.

A former Administrator-on-Duty (AOD) RN, who due to medical problems is unable to resume former duties, has been reassigned to oversee scheduling for the entire campus and to manage all overtime use. A procedure is going to be piloted that will require documentation and monitoring of justification for overtime, with Nursing Administration sign-off. The Ward Managers and RNCs will be re-trained to assure their competency in the use of KRONOS to determine on a daily basis when schedules need to be adjusted to avoid overtime.

Finding 2.2: Interviewed staff indicated that the use of mandatory overtime has increased over the last three months, particularly on the 2nd shift.

Background: Interviews were completed with eight staff members on the second shift. All indicated that overtime had increased during the past several months particularly on the second shift. Staff indicated that some of this was due to the need for coverage of summer vacations, which only serves to emphasize the on-going problem with staff shortages. In addition, staff relayed that overtime could be more problematic in some buildings than others because facility policy requires that staff cover their building. Half the staff interviewed had completed at least two overtime shifts a week over the past several months.

Recommendation: Explore the option of cross training staff facility-wide to increase the pool available for overtime shifts.

DMHMRSAS Response: There appears to be an inconsistency between the information given to the OIG interviewers and CSH data regarding overtime. The CSH KRONOS data for 3 months prior to the OIG visit demonstrates that, of the nursing staff working in Buildings 93 and 94 that evening, no staff members had completed at least two overtime shifts a week during that period as claimed. The majority of overtime shifts were voluntary rather than mandatory. Of the three staff working mandatory overtime in building 93 that evening, one had averaged 2 hours overtime per pay period in the 6 pay periods from May 10 through August 9, 2002. The second averaged 6 hours and the third

9 hours per pay period. It is unclear what the staff meant by the information that they conveyed to the interviewers.

All CSH civil patient nursing staff are cross trained across all civil patient wards. Forensic staff are cross trained across all civil patient wards in addition to forensic wards. (Civil staff are not cross trained to work in forensics due to the need to be extremely familiar with the additional security measures and due to class and compensation issues.) Although attempts are made to minimize the pulling of staff from one ward to the other, it occurs regularly in order to maximize staffing levels, provide necessary coverage and minimize the use of overtime CSH will continue to cross train staff across all civil wards and will continue to make assignments in a way that maximizes the numbers and expertise of existing staff.

Finding 2.3: The facility provides opportunities for staff to pursue career development.

Background: A review of administrative documents and interviews with employees indicates that the facility offers an opportunity for staff to receive a variety of training through orientation, in-services, annual re-certification, and advanced career training that is supported through reimbursement or scholarships. The facility budgeted funding in FY2002 and projected funding in FY2003 under two categories: Staff Training and Scholarships and Security Training. In FY2002 $43,700 was budgeted for Staff training and Scholarships and $7,640 was budgeted for Security Training. This funding was used to support 108 different training topics offered. Additionally, professional staff training totals over 2500 occurrences and 44 staff has been able to have career development training funded. Those that are attending external career development training are expected to share this education with staff, but the facility does not have a mechanism to track this process. Interviews with a select number of staff during the evening shift did not indicate that there was an enthusiasm to pursue any advanced career training. Staff did indicate that they were aware of others who the facility had supported either through tuition reimbursement or more typically through a willingness to adjust schedules.

In FY2003, the facility budget for Staff training and Scholarships was indicated to be $48,000 and $7,640 for Security Training. The brevity of the FY2003 information was due in large part to the timing of the inspection occurring right after the beginning of FY2003.

Recommendation: Expand the current focus of staff training to improving staff knowledge about the benefit of training to career development.

DMHMRSAS Response: All CSH employees are given information about tuition reimbursement for career development. Information about all LPN and RN schools in the area is disseminated and the Training Department has added a federal funding application to the information.

The SVTC Workforce Development Director will continue to provide direction to the Southside campus on workforce development. She is working with the local community college to facilitate staff participation in educational opportunities. In August 2002, the college entrance exam was provided to staff. Unfortunately, only one person of the 29 on campus who took it, passed.

The *School at Work (SAW)* program is being held on campus for 2 semesters. The Department of Labor *SAW* program is specifically designed to assist staff to obtain post-high school education. CSH currently has 6 participants in the first semester. Four additional staff signed up for *SAW*, but were unable to pass the qualifying test (Test of Adult Basic Education) which is written at a ninth grade level. Because of the high failure rate on the entrance exam, CSH is considering implementation of an 8-module remedial alternative called *Workplace Essential Skills.*

Experience at CSH has shown that career development related to DSA-level staff has involved MUCH remedial assistance, since many who are interested cannot pass qualifying tests. Therefore, CSH will continue to offer the current transition classes. Many of these staff want to expand their career prospects and are fully aware of the benefits of doing so, but are dealing with personal challenges (such as single parenthood, lack of funds, etc). A portion of them also need to first upgrade their skills before even beginning the career development opportunities.

The CSH Training Department will continue to encourage staff participation in the various staff development activities. CSH will also continue to work to provide new and innovative opportunities for training, knowledge and education that are realistic, convenient and affordable.

ACTIVITY OF PATIENTS

Finding 3.1: Record reviews revealed an integration between initial assessments, treatment planning and involvement in active treatment programming.

Background: Seven records were reviewed during the course of this inspection. All of the records demonstrated a link between the initial assessments and the treatment plan. Barriers to discharge were clearly identified. There was evidence that the barriers were a focus of clinical interventions. The treatment planning process matched the patients' identified problems, treatment goals and barriers to discharge with the curriculum offered in the psychosocial rehabilitation program.

The goals for interventions in the psychosocial rehabilitation programs have matured since the initial development of this service at CSH. Participant goals have moved from identifying the number of sessions a person would attend during any given week to more individualized goals for improving skills in key areas that often hamper the person's ability to successfully re-enter the community.

Recommendation: The documentation of treatment goals has significantly improved. Expand upon past successes through the development of realistic individualized treatment goals that continue to be based upon on-going clinical assessments.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the recognition of the improvements made to the documentation of treatment goals. The CSH Clinical Leaders of regularly conduct qualitative record audits and provide feedback to the treatment team members. The next phase of review will focus on realistic, individualized treatment goals based on current clinical assessment. The Clinical Leaders will continue to provide feedback to the treatment teams.

Finding 3.2: The facility has developed a mechanism for increasing patient involvement in active treatment programming.

Background: After management staff responsible for coordinating and providing oversight of the psychosocial program noted a decline in attendance in the scheduled classes, plans were made to create an environment that would increase each patients' likelihood for attending the agreed upon treatment programming. Observations by a cross-section of staff revealed that the Snozelan Rooms were the alternative of choice for an increasing number of individuals. Staff decided to close one of the two Snozelan Rooms as well as decrease the numbers of persons who could use the room at any given period of time. In addition, patients who decide not to attend their classes are required to inform their instructors of their intentions and have their instructors sign off on their sheets. It was discovered that when patients were expected to go to this much effort to not be in the classes, many choose to remain in the class. Follow-up tracking after implementing the new requirement has shown an increase in attendance.

Recommendation: The OIG commends the staff for identifying and addressing this problem. It is recommended that this information be shared with other facilities that have Treatment malls or psychosocial rehabilitation programs.

DMHMRSAS Response: DMHMRSAS concurs, and is pleased by the recognition given to this example of inter-disciplinary problem-solving related to patients' involvement in programming. On October 1, 2002, the CSH Director of Rehabilitation Services attended a statewide meeting of Rehabilitation Directors from the other state hospitals; and shared the facility's successful methods of increasing patient participation and making programs more meaningful to them.

OTHER ISSUES

Finding 4.1: The approval of policies and procedures reflecting changes in the human rights regulations has been delayed.

Background: Interviews with administrative staff revealed that the changes in facility policies and procedures, which reflected the changes as a result of the human rights regulations (effective in November 2001) has been delayed because there has not been adequate representation on the LHRC to review the facilities changes, which were due for completion July 1, 2002. Until these policies can be approved, the training of line staff has been delayed.

The LHRC is comprised of local citizens charged with the task of providing oversight and review of issues relevant to the rights of persons receiving treatment in programs operated or licensed by DMHMRSAS. This citizen's advisory group provides a valuable service to the consumer, but also has the potential of hampering the application of these rights.

It is the responsibility of the Office of Human Rights to assure that these committees function in such a manner as to assure the timely execution of their responsibilities. Alternatives need to be developed for the successful completion of committee duties when membership problems prevent or delay critical tasks from being completed in a timely manner. An example of a potential alternative might be to have members of other Local Human Rights Committees or the State Human Rights Committee within Virginia (who would be familiar with issues and be trained in the role and responsibilities of Human Rights Committee), be deemed as authorized substitutes until positions are filled such that quorum can be present in order for the committee to conduct its business. This is a critical role that is difficult to fill in many localities in Virginia.

Recommendation: Address the issue of delayed decision-making by LHRC by developing alternatives for completing committee functions in the absence of a quorum.

DMHMRSAS Response: The implementation of the schedule for the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, mental Retardation and Substance Abuse Services* was articulated in Commissioner Kellogg's memo of October 18, 2001. The schedule indicated that as of July 1, 2002, in order to provider to be in compliance with regulations, they must have their policies and procedures approved by the Human Rights Advocate. It was also required that the policies and procedures were to be submitted to the Local Human Rights Committee (LHRC) for review. The implementation schedule does not include a requirement for LHRC approval of the policies and procedures by July 1, 2002 or any other date.

Central State Hospital and the Human Rights Advocate have been working actively on the facility's policies and procedures since April 19, 2002. The policies and procedures have been reviewed and revised four times since then. To date, however, the Human Rights Advocate has not yet approved CSH's new policies and procedures. Once they are approved, the policies and procedures will be submitted to the LHRC for review.

Central State Hospital has submitted plans for the completion of the staff human rights training to the Office of Facility Operation/ Quality Assurance. These plans are not dependent on the actions of the Human Rights Advocate or the LHRC.

The revised Human Rights regulations require that a Local Human Rights Committee (LHRC) meet at least four times per year. The bylaws of each LHRC can increase the frequency of its meetings. The LHRC at CSH is one of the few that meets monthly; and this schedule was set to ensure more timely review of complaints. This LHRC unexpectedly lost several of its members in early summer 2002. The Committee cancelled its meeting in July and did not have a quorum at the August meeting. The State Human Rights Committee appointed five new members to this committee on September 6, 2002, and the CSH LHRC conducted a meeting with a quorum on September 13, 2002.

The successful functioning of the LHRC is a shared responsibility amount the providers, the Office of Human Rights and the state Human Rights Committee. The Office of Human Rights and the SHRC monitors the activities of each LHRC regularly. The State committee has the authority to reassign responsibilities to other committees and has done so when necessary.